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of operational beds at OMH hospitals is less than 80%, the hospital will be reimbursed at the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate. Operational beds are defined as the projected census for the upcoming year for the Office of Mental Health psychiatric hospital system as derived from the Executive Budget. In determining whether the statewide occupancy rate meets the 80% requirement, for purposes of determining the applicable reimbursement rate, alternate care days will not be counted as occupied beds.

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IX. DISPROPORTIONATE SHARE ADJUSTMENT

The Medicaid payment rates for OMH facilities will be adjusted in accordance with Sections 1902 (a)(13)(A) and 1923 of the Social Security Act to account for the situation of OMH facilities which serve a disproportionate number of low income patients with special needs. The adjustment will be made if either the Medicaid inpatient utilization rate for OMH hospitals is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or if the low income utilization rate for OMH hospitals exceeds 25 percent.

The Medicaid inpatient utilization rate is defined as the total number of Medicaid inpatient days in a cost reporting period divided by the total number of the hospitals inpatient days in that same period.

The low income utilization rate is defined as the sum (expressed as a percentage) of the fraction calculated as follows:

- o Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments for the latest available cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,
- o The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period less the portion of cash subsidies reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient service in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances

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and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third-party payers, such as HMO's, Medicare or Blue Cross.

If the Office of Mental Health hospitals qualify for an adjustment, the rate will be increased by the greater of the percentage increase allowed under Section 1886(d) (5) (F) (iii) or the percentage increase allowed under Section 1886(d) (5) (F) (vii) of the Social Security Act for hospitals which qualify for a disproportionate share adjustment under the Medicare Program.

For purposes of determining whether an adjustment is appropriate, and in the calculation of the adjustment, the OMH's hospitals will all be considered as one urban hospital in recognition of the statewide Medicaid rates utilized by the OMH and the fact that the OMH serves a predominately urban population.

Medicare Adjustment Under Section 1886(d) (5) (F) (iii)

The Medicare adjustment required under Section 1886(d) (5) (F) (iii) is 30 percent through September 30, 1991 and 35 percent beginning October 1, 1991.

Medicare Adjustment Under Section 1886(d) (5) (F) (vii)

The Medicare adjustment required under Section 1886(d) (5) (F) (vii) for hospitals located in an urban area and which have more than 100 beds is in accordance with the following formula for the period January 1, 1991 through September 30, 1993 for those hospitals which have a disproportionate share adjustment percentage greater than 20.2: $(P-20.2) (.7) + 5.62$. Effective October 1, 1993, the formula becomes $(P-20.2) (.8) + 5.88$ and effective October 1, 1994, the formula becomes $(P-20.2) (.825) + 5.88$.

"P" in the above formula is the hospital's disproportionate patient percentage as defined under Section 1886(d) (5) (F) (vi). In that clause the disproportionate

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patient percentage is defined as "the sum of-

- (I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title, and
- (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital's patient days for such period."

To calculate the percentage under (I) above, the Office of Mental Health may utilize a statistically valid sample of actual paid title XVIII Part A days to determine the percentage of those days to be included in the formula. If the Office of Mental Health chooses a sampling methodology, the sample must be of at least a six month period within two years prior to the beginning of the rate period.

For purposes of calculating the percentage under (I), the phrase "patients who ... were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act" is defined as those patients whose assets and income are such that they meet the federal criteria for supplemental security income benefits for individuals living alone.

The percentage adjustment developed under Section 1886(d)

- (5) (F) (vii) will be rounded to the nearest percent.

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The disproportionate share percentage adjustment will be included in the Medicaid rates for the OMH hospitals by multiplying the greater of the adjustments resulting from either the percentage allowed under Section 1886(d)(5)(F)(iii) or the percentage calculated under Section 1886(d)(5)(F)(vii) times the rates as calculated under this State Plan without the adjustment and adding the resulting per diem to the rates as calculated without the adjustment.

Supplemental Low Income Patient Disproportionate Share Adjustment

On and after October 1, 1992, a supplementary low income patient disproportionate share adjustment for public psychiatric hospitals shall be calculated [in accordance with Part I, section 86-1.84 pursuant to subdivision (b)(2)(ii) of that section on and after October 1, 1992] by multiplying the applicable supplemental percentage coverage of need amount for the hospital, as specified in the scale below, by the hospital's need calculated using 1989 data. Need shall be defined as inpatient losses from bad debts reduced to cost and the inpatient costs of charity care increased by any deficit of such hospital from providing ambulatory services, excluding any portion of such deficit resulting from governmental payments below average visit costs, and revenues and expenses related to the provision of referred ambulatory services. Grants received to finance operating expenses, and the income and, where appropriate, principal, from those endowment funds and special purpose funds whose use is restricted to pay for the costs of care provided to those unable to pay, shall also be considered in the calculation of outpatient deficits and inpatient bad debts and charity care. The low income patient percentage shall be defined as the ratio of the sum of inpatient discharges of patients eligible for medical assistance pursuant to State Law, inpatient discharges of patients who are uninsured and who are not full pay patients and inpatient discharges of charity care patients divided

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by total patient discharges expressed as a percentage. The percentages shall be calculated based upon 1989 data developed by the Office of Mental Health.

The scale utilized for development of a supplementary low income patient adjustment for a public psychiatric hospital shall be as follows:

<u>Low Income</u>	<u>Supplemental Percentage</u>
<u>Patient Percentages</u>	<u>Coverage of Need</u>
<u>35+ to 55%</u>	<u>20%</u>
<u>55+ to 60%</u>	<u>25%</u>
<u>60+ to 65%</u>	<u>30%</u>
<u>65+ to 70%</u>	<u>37.5%</u>
<u>70+%</u>	<u>45%</u>

[The supplemental percentage coverage of need shall not be allocated between case based and exempt units and the low income patient percentage for public psychiatric hospitals shall be calculated based on 1989 data developed by the Office of Mental Health.] The adjustment for public psychiatric hospitals shall be limited such that this amount when added to the disproportionate share adjustment described above shall not exceed 90% of need.

X. TRANSFER OF OWNERSHIP

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

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XI. Additional Disproportionate Share Payment -

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid-eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, the disproportionate share adjustment described in section IX. However, the calculations of hospitals' bad debt and charity care costs which are partially covered by the disproportionate share adjustment described in section IX, does not include costs of services to any person for whom an additional disproportionate share payment has been made under this section.

These additional payment adjustments are made by the Department to disproportionate share hospitals who have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program (except for their current residential status). These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.

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A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

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**METHODS AND STANDARDS OF SETTING PAYMENT RATES FOR
HOSPITALS LICENSED BY THE OFFICE OF MENTAL HEALTH**

In accordance with the New York State Mental Hygiene Law, the State's Office of Mental Health establishes Medicaid rates of reimbursement for hospitals issued operating certificates by the Office of Mental Health. The class of facilities defined as hospitals includes the subclass of Residential Treatment Facilities for Children and Youth ("RTFs") which furnish inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs. Medicaid rates established by the Office of Mental Health must be certified by the Commissioner and approved by the Director of the Budget. The Methods and Standards set forth below do not apply to hospitals operated by the Office of Mental Health or to hospitals licensed by the Department of Health.

**A. HOSPITALS OTHER THAN RESIDENTIAL TREATMENT
FACILITIES FOR CHILDREN AND YOUTH**

1. OPERATING COSTS

Medicaid rates are established prospectively and are all inclusive, taking into account all allowable patient days and all allowable costs and are effective for a twelve month period. Payment rates for a rate year are based on base year financial and statistical reports submitted by hospitals to the Office of Mental Health. The base year is the fiscal year two years prior to the rate year. The financial and statistical reports are subject to audit by the Office of Mental Health.

Allowable base year operating costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. To be allowable, costs must be reasonable and must relate to patient care. Allowable costs may not include costs for services which have not been approved by the Commissioner.

Hospitals which have no previous costs or operating experience will submit a budget report as the basis for calculating a prospective Medicaid rate. The budget report will contain all proposed revenues and expenses for the period under consideration. The operating cost component of the rate will be the lower of the calculated per diem, utilizing the approved budgeted operating costs and the approved budgeted patient days, or 110% of the statewide weighted average of the operating cost component of all private psychiatric hospitals. The hospital is required to submit a cost report after it has operated for six months at a minimum occupancy level of at least 75%. This cost report will be used to set a cost based rate for the hospital effective the first day of the cost report period.

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In determining allowable operating costs for any base year there is applied a limitation, which is derived from the fiscal year one year prior to the base year, increased by the Medicare inflation factor for hospitals and units excluded from the prospective payment system. Both the base year and the limitation are subject to an administration cost screen. The administration cost screen is derived from the costs in the fiscal year one year prior to the base year (i.e. the same cost year the limitation is derived from), and is the group average cost plus ten percent. Separate administration cost screens are calculated for hospitals greater than 100 beds (group one), and hospitals less than 100 beds (group two). The allowable costs are the lesser of the base year operating cost or the limitation. The allowable operating costs are then increased for inflation to the rate year by the Medicare inflation factor described above, except that the 1996 Medicaid rates will not include an inflation factor for 1996 effective July 1, 1996. Such inflation factor shall be as determined by the Federal Government each year prior to the effective date of the payment rates calculated herein.

Appeals from rate determinations are heard by the Commissioner. The Commissioner may hear requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in services, programs or capital projects approved by the Commissioner in connection with OMH's certificate of need procedures. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

2. CAPITAL COSTS

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.

The allowed capital cost component of the budget based rate will be based upon approved annual budgeted costs and approved budgeted patient days retroactively adjusted to actual certified costs divided by the higher of the actual patient days or the approved budgeted patient days.

Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

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